

Traditional Practices

Kaway had been blessed with as many boys and girls as she wanted. Although her husband Kantinka had thought he would want more children, he agreed that adding more members to the family would be more of a burden than a help. He could remember times when water and food were scarce, and he feared for the children he already had and loved. On the advice of a village elder, he and Kaway placed herbs in her vagina before intercourse. However, it soon became clear that the herbs did not work, as another baby was on the way.

Each society hands down traditions from generation to generation by teaching certain attitudes, practices, beliefs, legends, customs, and habits. There are traditional beliefs and practices in all areas of life, including reproduction. Throughout history, the traditional family planning practices used to space children have been rich and varied.² The creative and occasionally life-threatening techniques used to limit childbearing show how intensely women and men have tried to control reproduction and sexual practices.

WHAT ARE THE TRADITIONAL METHODS?

Modern family planning methods are an extension of the traditions described in the chapter. Although modern methods are more effective

and sometimes safer than most traditional methods, many traditional methods continue to be widely used. Many of the traditional methods may be ineffective; others are harmful.

The rapid rates of modernization, urbanization, and social change experienced in African countries make it difficult to determine how often traditional methods of fertility regulation are still used. Reports from earlier in this century indicate that use of these methods was widespread. More recent reports suggest their use continues, at least to some degree. Among the traditional methods, withdrawal is the most commonly practiced.⁸ (See Chapter 19 on Coitus Interruptus.) Table 2:1 shows the percentage of women who use a modern method and the percentage who use a traditional method. In Ankole, Uganda, for example, about one-third of women have used traditional methods.⁶

How important these traditional practices are to your clients will depend to a large extent on where you provide family planning and other maternal and child health services. People working in urban clinics and hospitals will probably see fewer individuals who actively use traditional approaches to child spacing. On the other hand, health workers in rural settings are more likely to provide services to women who frequently use traditional means to regulate their fertility. Some rural providers may themselves use traditional methods and believe them to be effective.

Table 2:1 Family planning methods currently used (in percentages) by married women of reproductive age

Country	Any method	Traditional methods	Modern methods
Burkina Faso	10	6	4
Cameroon	14	10	4
Egypt	47	2	45
Ghana	20	10	10
Kenya	33	6	27
Madagascar	17	12	5
Malawi	13	6	7
Namibia	30	3	26
Morocco	42	6	36
Niger	4	2	2
Nigeria	6	3	4
Rwanda	7	3	5
Senegal	7	3	5
Tanzania	18	5	13
Togo	12	9	3
Tunisia	51	9	41
Uganda	15	4	9
Zambia	26	12	14
Zimbabwe	48	6	42

Source: Robey et al. (1992)

BEHAVIORAL PATTERNS

Abortion has concerned people for centuries, and it has been employed, to some degree, in most societies. Perhaps more important than traditional contraceptives and abortifacients are the cultural practices related to reproduction and sexuality that affect fertility. See Table 2:2. In the most desperate of circumstances (in Africa and elsewhere), unwanted offspring have been subject to infanticide, and women pregnant outside of marriage have been disowned and, in rare circumstances, put to death. These practices can only be condemned and must be actively extinguished.

Table 2:2 Traditions that may decrease fertility in a society

<ul style="list-style-type: none">• Traditions encouraging <i>breastfeeding</i>• Traditions leading to <i>abstinence</i>• <i>Mechanical, spermicidal, and systemic preparations that prevent pregnancy</i>• Traditional practices causing <i>abortions</i> or <i>infanticide</i>• Societal traditions causing <i>infertility</i>• Traditions leading to <i>death of women who are pregnant or who have intercourse outside marriage</i>

TRADITIONS LEADING TO BREASTFEEDING

Among the African nations, there is a tremendous range in the percentage of people who rely on breastfeeding for contraception. Because lactation has definite contraceptive effects and is so widespread, it is one of the most important contraceptive methods currently limiting female fertility. (See Chapter 12 on Lactation and Postpartum Contraception.) In addition, many cultures discourage sexual intercourse while the mother is breastfeeding. Surveys indicate that lactation and postpartum abstinence are still important in their effect on fertility in some parts of Africa.

TRADITIONS LEADING TO INCREASED ABSTINENCE

A number of customs and traditions increase the likelihood of abstinence in a society. The culture may encourage postpartum abstinence for a variety of reasons, ranging from multiple wives (polygamy) to concern about postpartum infection, healing of the episiotomy (or tear), or maternal depletion syndrome. Because of mistaken notions that semen pollutes breast milk or that sexual intercourse causes malnutrition in the suckling infant, abstinence may also be practiced to space births so that each child will receive enough breast milk to survive.

In addition to abstinence after childbirth, and especially during breastfeeding, there are other culturally mandated periods of abstinence that affect fertility. The value placed on virginity in many areas prohibits the beginning of sexual activity until a girl is married. In some areas, women are supposed to abstain indefinitely from intercourse once they have become grandmothers. Thus, there are areas in Africa where abstinence shortens a woman's reproductive period at both ends of her reproductive life span, determining when she becomes sexually active as well as when she stops.

TRADITIONAL METHODS THAT PREVENT PREGNANCY

Without a clear understanding of the process of pregnancy, women and men worldwide have tried countless methods to avoid pregnancy. The traditional methods outlined in Table 2.3 highlight the human potentials for ingenuity and playfulness, as well as for frustration and desperation.

Table 2:3 Ineffective or unsafe traditional methods

Mechanical barriers

- Sponge and spongy substances
- Lemon halves, shelled out and placed over cervix (similar to cervical cap)
- Linen pads in vagina
- Crocodile or elephant dung
- Condom-like materials: cecum and bladder of various animals, linen sheaths, receptacles shaped like condoms that are placed into vagina

Spermicidal materials: Lemon juice; cola drinks; vaginal pill made of tannic acid; pastes and gums of honey, natron, sodium bicarbonate, oils, ground betelnut

Douches of alum, white oak bark, hemlock bark, red rose leaves, raspberry leaves, roots, zinc sulphate, sodium bicarbonate, coca cola

Removal of semen from vagina by mechanical methods (such as wiping with a cloth or jumping up and down)

Pessaries or suppositories

- Gold ball at the base of the "temple of love"
- Block pessary with 4 concavities
- Beeswax
- Opium ball
- Stones placed in the uterine cavity

Systemic preparations

- Cup of roots to make woman sterile, such as worm fern roots
 - Sabine (*Juniperus sabina*) to prevent conception
 - Marjoram, thyme, parsley, and lavender teas
 - Willow tea
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SOCIETAL TRADITIONS CAUSING INFERTILITY

Historically, certain societal traditions have increased the likelihood of male or female infertility.

Prostitution can increase a woman's risk for sexually transmitted infections, which can lead to pelvic inflammatory disease (PID) that, in turn, may contribute to infertility. Prostitution has also contributed to the transmission of acquired immune deficiency syndrome (AIDS).

Female genital mutilation (circumcision) has caused serious PID and infertility in women because of infectious complications that frequently follow the genital mutilation procedure. Some of these procedures merely entail removing the prepuce of the clitoris and the posterior, larger parts of the labia minora. A more extensive procedure called "excision" or "reduction" removes the glans and the adjacent parts of the labia minora. The most extensive procedure is called "excision and infibulation." The entire clitoris, all of the labia minora, and part of the labia majora are surgically removed, and the vaginal opening is almost entirely closed. Female genital mutilation is still commonly practiced in Africa, where more than 110 million women have been circumcised.¹

These operations are rarely performed by medical personnel, and complications can be very severe. One of the significant long-term complications is impaired sexual functioning. A study in Egypt compared 1,900 circumcised women with a similar group of uncircumcised women. Half (50%) of the circumcised women reported having difficulty in permitting penile penetration or suffering pain during intercourse. Fifty-six percent of these women failed to achieve orgasm during intercourse. Perhaps because of these problems, 60% of the circumcised women engaged in sexual intercourse far less often than did women who were not circumcised.⁴

Male genital mutilation (castration) of men (making them eunuchs) was an ancient practice that rendered them incapable of impregnating women.

PLANTS AND OTHER SUBSTANCES

Locally available plants have traditionally been used in a variety of ways to control fertility. More than 500 different plants and substances in Africa have been used as abortifacients or contraceptives.

Plants are used in other ways as well. The oil of the seeds of *Buchholzia macrophylla* is said to have an estrogenic effect and has been used by women in Zaire to reduce menstrual flow.² Many plants, either drunk as teas or rubbed on the breasts, are used by women to stimulate the flow of breast milk. Other plants are used as spermicides,⁶ contraceptives,¹⁰ or labor-inducing agents.⁹

Women often place household substances such as aspirin, lemon juice, and black pepper into their vaginas prior to intercourse.⁵ Women may also place substances, many of which can be harmful, in their vaginas following intercourse. These douches may contain hot water with salt, vinegar, lemon juice, alum, soap, or potassium.³

WHAT TO DO?

Family planning providers must ask clients whether they have been using a traditional practice. Assess the effectiveness and safety of these practices as well as their compatibility with the various modern methods of contraception. Some clients may find modern methods easier to understand when they are compared to the beliefs about traditional methods.

While traditional practices are slowly disappearing, there is ample evidence that some traditional forms of fertility regulation are still fairly common. As one who delivers family planning services, you must be able to determine whether a woman is using a traditional method to regulate her fertility, whether she is using the method conscientiously and effectively, and whether use of the method is causing her any problems. Only when you have these facts will you be in a position to help her make family planning decisions that she will be able to carry out with confidence.

DOES THE CLIENT USE A TRADITIONAL METHOD?

Ask the client whether she uses any means to space her births. These questions may serve as a guideline:

- Do you breastfeed your children? How long will you breast-feed before you begin to supplement the child's diet? How long will you breastfeed before weaning the child completely?
- Do you completely abstain from sexual intercourse while you are breastfeeding? How long will you abstain? How long are you supposed to abstain?
- Do you use any means of contraception at all, especially methods that you have not received from a clinic or health professional?

If the woman answers "yes," and she breastfeeds and abstains for a substantial period of time after giving birth, she is probably a family planner. Additional information is needed; specifically, you must determine how reliably this woman adheres to traditional family planning practices or the lactational amenorrhea method (LAM, see Chapter 12 on Lactation and Postpartum Contraception), and how effective her method of choice is.

WHAT ARE THE CLIENT'S PLANS FOR FAMILY SIZE?

Use these questions as a guide to getting the extra information you need:

- How many children do you have? How many do you and your partner want to have?
- How far apart are your children in age? How far apart should children be spaced for health or economic reasons?
- How long will it be before you want to have another child?

If the woman has more children than she intended or if her children are more closely spaced than she had desired, recommend a modern method of contraception. The traditional method she has used may have required long periods of sexual abstinence that she and her husband have found difficult. Modern contraception may be easier for her to use and will allow her greater sexual activity.

If the answers to these questions reveal that the woman is controlling her fertility to her satisfaction through traditional means, you need to investigate the safety of her method. This step may be more difficult. If the woman is effectively spacing her births through a combination of breastfeeding and abstinence, there is nothing safer. If this is the case, the best course of action is probably to recommend a barrier method of contraception as a backup to her traditional practices. For example, you might recommend that the woman use foam or condoms just in case her or her husband's resolve to abstain should weaken.

Completely replacing her traditional practice with a modern method of contraception may not be productive. In many places, particularly in rural areas, there are still difficulties in maintaining a consistent supply of contraceptives. If you cannot guarantee that your client will be able to obtain the supplies she needs, you may be doing her a disservice by disrupting her traditional practices and replacing them with interrupted coverage from modern contraceptives. Furthermore, some types of oral contraceptives (the combination pills) should not be prescribed to lactating women. If used improperly, they can decrease the milk yield and shorten the period of lactation (see Chapter 12 on Lactation and Postpartum Contraception and Chapter 13 on Combined Oral Contraceptives). In cases where the period of sexual abstinence is directly related to breastfeeding, improper use of a combination pill could expose a woman to another pregnancy sooner than if she had followed her traditional practice.

In the case of traditional contraceptives, however, it is difficult to determine how safe they are for the user. There are many types in use and many different means of using them. Active agents have not been identified for many of these substances. The decision about the safety of these methods must be *yours*. If you have any doubt at all about the safety of her contraceptive, recommend a modern method.

IS THE CLIENT WILLING TO SWITCH FROM TRADITIONAL TO MODERN?

In general, if a woman is willing to use a traditional contraceptive, she may be willing to use a modern method, especially one that is similar. For example, women who are accustomed to using traditional barrier methods that require vaginal insertion may be more willing to switch to a diaphragm or foam. Similarly, women who use traditional methods that are taken orally may be candidates for the pill. Stressing the overall effects on her health may convince her to switch to a modern method.

Before you recommend such a switch, however, you should try to determine how receptive the woman is to changing her method and using modern contraception. If she is resistant to change, try to determine the source of that resistance. Consider the following questions in each case:

- Will giving the woman contraception put her in disfavor with her husband? Is he aware that she is receiving care at your clinic?
- Will it open her to criticism from the other women in her group?
- Will she be in disfavor with her mother? Her mother-in-law? Her grandmother?
- Does she have the freedom to get to the clinic when she needs to, or is it difficult for her to leave her household?

If the woman appears to be socially free to use modern contraception, recommend that she do so. If she is not socially free, your responsibility goes beyond providing contraceptive services. Counsel her about the pressures she encounters, reinforce her decision to use a modern method, and help her develop good justifications for the use of her method. Assure her that she can contact the health clinic for further reassurance, for answers to questions, or for help in discussing with others their concerns about her use of the contraceptive. It is preferable to schedule a return visit, even if her method of choice does not require it, to check on her progress and to help her with any problems—medical or social—she may be having with its use.

It is difficult to make comprehensive recommendations to all women regarding the use of traditional family planning methods. The preceding series of questions are intended to help you arrive at a suitable solution. Whatever the method, it must be not only safe and effective, but also suitable for the woman so that she continues to use contraception effectively.

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